Public Comments for Children with Serious Emotional Disorders Waiver Amendment

Effective Date: 7/1/21

Number	Date Received	Comment	Status Result Change/No Change-explain
1	3/16/21	The IPN response process is very cumbersome for potential CSED families. I am assisting families from SAH and siblings of CSED with the application process. We submit the app, we get the IPN information and list of providers from Kepro. We then complete the scheduling and IPN response. If any changes are made to scheduling of evaluation, etc. an entire new form/IPN response needs recompleted and resubmitted. If we could just notify the Kepro agent working on the case of any changes it would make the process easier. Grandparents and guardians really struggle with this and completing the forms. I have been completing them for the families as a courtesy, but it is not billable and considered voluntary.	We appreciate this comment and have made adjustments to the waiver medical eligibility process beginning 7/1/2021 that should make the process faster and provide additional application support. These changes are reflected in the proposed waiver amendment. The Independent Evaluator pool is being expanded so there will be more evaluators to choose from and KEPRO will be assisting the applicant (family) with making appointments. Status: No change
2		It would be VERY helpful if we could expand the definition of **assistive goods and equipment**. The definitions per Chapter 502 of the manual are as follows: ***Assistive Goods:*** *Documentation for equipment covered under the following Goods and Services must be specified in the Initial and/or master PCSP of the member. The plan may be incorporated into the Initial or Master Service Plan, or after referencing the service on the Service Plan, be a separate document created by the professional clinician. The plan must be signed by the clinicians responsible for implementing the service. Goods and services must be purchased from an established business or otherwise qualified entity or individual and must be documented by a dated and itemized receipt or other documentation.* ***Assistive Equipment*** *refers to an item or piece of equipment that is used to address the member's needs that arise as a result of their SED. The*	Thank you for your comment. The Assistive Goods and Equipment Service is designed in alignment with the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS) definition. Assistive goods and equipment must "increase, maintain, or improve functional capabilities of the member" and "be in response to goals in the member's Plan of Care and meet medical necessity requirements." If a request related to assistive goods and equipment is detailed in the member's plan of care and also meets CMS requirements for the service, it should

		equipment should increase, maintain, or improve functional capabilities of the member, assist them to remain in the home and/or community and avoid an out-of-home placement. As a manager of services, I have noticed clients living in poverty struggle with things that are beneficial to treatment for example, a client that needs to work on social skills in the community. The respite worker could take them for ice cream, but the family may not be able to afford that meal. I have had provider agencies and even myself cover the cost of these things. Also, things that could be beneficial in therapeutic treatment like community classes like gymnastics or Karate including therapy goals such as a positive behavior reinforcement plan if the client is doing ABA. Materials are necessary for therapeutic intervention, and the providing agencies are currently covering the cost of these items. As a social worker well versed in resources due to SAH implementation, in some areas, we do really well in getting these services donated or getting it covered somehow. However, in most rural, poverty-stricken areas it is not possible and the client is left without. If the definition could be expanded to include things the team considers therapeutically or socially necessary, it would be a big help to the members in areas we serve. Lastly, If this could be covered under the Case Management Agency, it would be helpful. As CMs keep track of all services anyway. They could include the documentation for goods and services in the Master plan. Ex. Member B has in his ABA plan that he has a dx of Autism and needs to work on social skills and making friends. The team could agree to try art classes and pay 50.00 a month for biweekly art classes until the next update meeting (3 months). Also, the respite provider is going to take him out for a meal to practice social skills 1x a month with a limit of $15.00 per. Then, ABA therapist has asked for $25.00 for specific sensory materials needed from the dollar store. This would be documented in the plan by the CM and approved by BMS. So when the providing agency completes the service, they would submit receipts to the CM agency for reimbursement, the CM	be submitted to the MCO for consideration. BMS encourages providers to make the request and if the request cannot be approved under this category under the waiver, the MCO Care Manager may be able to refer the Wraparound Facilitator to other resources for funding of supplies to assist with working on treatment goals. Further, with regard to the comment related to art classes to support therapeutic goals, the CSEDW also includes specialized therapy as a service, if the Child and Family Team believes that treatment modality might be beneficial in helping the waiver member to meet their goals. We recommend discussing these cases with the MCO Care Manager to identify service and funding options for meeting the waiver member's needs. Status: No change

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		agency would then submit to Aetna for reimbursement and keeping track of units utilized. So (50.00 x3) + (15.00x12) + (25.00) = $355.00 would be the amount approved. I feel as though this would give more opportunities to members if the CSED Team and families had more freedom to decide what would benefit the client as far as this service goes. Sometimes the smallest things can make the biggest difference in treatment.	
3		Lastly, I feel as though it would be very helpful as we continue to grow the program to have maybe a CM mentor resource with CMs that have been doing this since the beginning to help newer CMs? Not an agency mentor, but a program mentor. All agencies are different, but the program expectations are the same. Some people do not have support in their roles from agency or supervisor (like they should) or don't have the confidence to seek help when needed from "higher ups" afraid they will be judged. This isn't helping the program to grow. It is much easier to talk to/seek help from someone that is an "equal" and it will help to ensure continuity of care, as well as, prevent instances where the CMs change and the receiving CM is left with a mess. (happened to me). It would be super simple to implement and newer CMs would be more than welcome to shadow meetings, review docs, etc. (with confidentiality statements an ROI's signed of course).	We appreciate this suggestion. Currently, the MCO is responsible for training and technical assistance for providers by policy. We will share this suggestion with the MCO for consideration. Status: No change
4	3/30/21	. To Whom It May Concern I am writing to ask that the powers that be review and amend this program to enable more children and their families receive the treatment they need. As the program is currently structured to operate, it requires the practitioners to be in-network or partnered with Medicaid. This rules out many different treatment centers that offer services that can assist a child's situation.	Thank you for your comment. Currently, the CSEDW is only eligible for the member that is approved for West Virginia Medicaid-Mountain Health Promise. This is as following the federal guidelines for the 1915 (c) waiver. Status: No change

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		I'll speak to our situation as an example. Our child is severely traumatized with PTSD, Anxiety, RAD and is showing markers for more serious DSM diagnosis that aren't able to be diagnosed in a child of her age. For the past seven years traditional therapies have been employed to help our child address and come to terms with the trauma experienced in the biological family of origin. Our child has been in our home for 7 of their 13 years. We're closely working with the current therapist and a board of trauma specialists who recommended ITR therapy for our child. ITR is an outpatient treatment (requires travel to) in Stubenville, OH as the Charleston, WV branch is currently closed due to COVID. Thirty hours are estimated to do intensive therapy with our child, working on documenting the trauma and giving it a beginning, middle and end – thus moving the trauma that is being re-experienced daily into a complete file that can transition from the right brain to the left. This move from the right hemisphere to the left ends the re-experiencing and the trauma can now be unpacked and dealt with in the left brain by cognitive behavioral therapies and talk therapy. Our child's trauma is mainly preverbal and needs this type of approach to give voice to our child with how to use the tools and treatment available with the current therapist. This treatment is about $6000-8000.00 which is significant for a family. However, in light of the costs of institutional care as a teen or adult, this is a small drop in the bucket in comparison. Whatever costs Medicaid would cover if this provider was in partnership should also be available to the family as a reimbursement if the child qualifies as Serious Emotional Disorder. We should not legislate good medical care based on if they are in a partnership with Medicaid. If its $.40 on the dollar, that is a significant help to a family in crisis with a child with these life-altering disorders. They	

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		design and heart behind this program is correct, but there are significant lapses in tying the treatment available to the individuality of the children who need the help. This should not be limited but open to the vast and varied legitimate options that are specialized to assist a wide range of disorders and trauma. Thank you for this consideration.	
5	3/30/21	State's Wraparound Initiative (page 2) Comment: Waraparound programs are per diem programs and not fee for service. The programs are managed by one provider and not two or more. Wraparound service already exist, and this level of care was supposed to be a higher level of care than transitional wraparound.	Thank you for this comment. Medicaid does not pay per diem for CSEDW because of the federal billing codes that are usually 15-minute units. Status: No change
6	3/30/21	Purposed Amendment: Change Case Manager to Wraparound Facilitator (page 2) Comment: leave name as case manager	The decision was made to rename case manager to wraparound facilitator to align with the other wraparound programs available in Bureau for Behavioral Health and Bureau of Children and Families Status: No Change
7	3/30/21	Qualifications for individuals Performing initial Evaluation (page 40) Comment: Add a thorough review and documentation of records in the initial evaluation. History is lacking in the initial evaluation.	If the member brings their information with them, then the evaluator will utilize that information. Status. No change.
8	3/30/21	Wraparound Facilitator Agency and their agency to provide all other CSED services (page 46)	It is a federal mandate to separate wraparound facilitation from all other CSED services, unless there are no other providers in the area that can provide that service. BMS will review these on a case by case basis and will grant waivers when appropriate.

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		Comment: This is not CSED mandate, but a choice by the state. One agency can do both	Status: No change.
9	3/30/21	In-home Respite may be provided in the local public community if delivery begins and ends in the member's home. Out of home respite may be provided in the local public community and begins and ends in the member's certified therapeutic foster care home (Page 56) Comment: This requirement limits the number of respite providers and services provided.	This is an error that has been corrected in the amendment. Out of home respite must occur in a certified therapeutic foster care home but is not available to members that are in foster care. This service is only available through this waiver for children in natural family settings. Comment: Change.
10	3/30/31	**Case manager meets in person at least weekly with the member in the home (Page 62) Comment:** Why changing from monthly to weekly?	This is to align with the National Wraparound Initiative model. Status: No change.
11	3/30/31	**The Wraparound Facilitator and the agency that employs them, cannot provide any other waiver or state plan services for the member (page 63)** **Comment:** Why is this a requirement?	Duplicate: See number 8. Status: No Change.
12	3/30/21	**Certified Wraparound Facilitation Agency (page 63)** **Comment:** What is this and who in the state meets this designation?	A certified Wraparound Facilitation Agency, formally known as case management agencies who are also licensed behavioral health centers, are agencies that have staff who are certified to provide to assess a member with the CANS model. The list will be posted on the CSED site. Status: No change.

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13	3/30/21	**Case Manager must have 2 years of experience. Family Support and mobile crisis both require only 1 year of experience (Page 64)** **Comment:** Change to 1 year of experience Difficult to hire case managers with 2 years of experience.	Due to the level of intensive services required for this waiver that provides wraparound facilitation, Bureau for Medical Services has implemented the 2 years' experience. Status: No change.
14	3/30/21	**Person-centered Service Plan (Page 66)** **Comment:** Change name to Plan of Care	Thank you for bringing this to our attention. Status: Corrected the terminology to reflect Plan of Care and not Person-Centered Service Plan.
15	3/30/31	**The in-home therapy providers will implement and oversee Mobile response activities (Page 71)** **Comment:** This only works if both services are provided by the same agency.	Thank you for this comment. Nothing in the manual prevents this from being offered from the same agency. Status: No change.
16	3/30/31	**The in-home worker may participate and bill for attending POC meetings (Page 71)** **Comment:** Billing for attending POC meetings as well as other case management activities required can only be provided by the in-home therapist.	CMS has requested that BMS remove this language from all CSED services. CMS considers these to be administrative functions. Status: Changed.
17	3/30/31	**In-home family therapy must be performed by a minimum of master's level therapist is licensed or under supervision (page 72)** **Comment:** Or under master's level licensure supervision	This wording has been changed to reflect your suggestion. Status. Change

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18	3/30/31	**LSW, AADC, and ADC (Page 72)** **Comment:** Remove (may be BA level staff unlicensed and not under supervision)	We are unclear what is meant by this comment, however, the regulations are listed below. Bachelor's Degree in Human Services without Alcohol and Drug Counselor Credential*: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor The following providers do not require additional supervision*: • Licensed Independent Clinical Social Worker • Licensed Psychologist • Board Supervised Psychologist • Licensed Professional Counselor • National Certified Addiction Counselor II • Master Addiction Counselor • Bachelor's Degree in human services with Alcohol and Drug Counselor Credential *Certification requirements for West Virginia Association of Alcoholism and Drug Abuse Counselors, Inc. (WVAADC) may be different than those included above. This policy is not meant to circumvent any requirements as set forth by this organization. Status: No change
19	3/30/21	**Mobile response services are 24-hour services designed to respond immediately. This service may only be <u>delivered in an individual one-on-one session</u> (Page 74)** **Comment:** Change to: This service is intended to be provided in-person whenever possible.	Mobile Crisis is to be a one-on-one session. One staff can provide crisis intervention while another is driving to the destination in which the member is located. Right now, during the global pandemic, appendix K allows for this service to be delivered via telehealth or telephonically. Once the pandemic is over, the service must be provided in person. Status: No change.

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20	3/30/21	**The Wraparound Facilitator will remain the primary contact for CSEDW, however the agency providing the in-home family therapy will implement and oversee the Mobile Response activities (Page 74).** **Comment:** This is an example of the disjointed nature of the model. The Mobile Crisis Provider should not have to report to the case management agency, the direct service agency, and the MCO agency.	Under this waiver, the Mobile Crisis Provider should send documentation of the crisis event to the case management agency, the direct service agency and the MCO Agency to ensure all agencies working with this member and their family is apprised of any crisis intervention so that they can work together to assist the member and family in the services provided moving forward. Status: No Change.
21	3/30/21	**Peer Parent Support Services (Pages 78-81)** **Comment:** What are the qualifications or what certification is required for this position? There is no peer parent network. What allowances or modifications can be made to provide parent education in the absence of the peer parent network?	These are the qualifications: Must have a contract with the MCO. Agency staff must have current CPR and First Aid cards, have acceptable state and federal fingerprint- based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS. Must also have the following training as required by BMS and OHFLAC within one month of employment: First Aid and CPR; Crisis Intervention and Restraint; Suspected Abuse and Neglect; Member Rights; Crisis Planning; Emergency and Disaster Preparedness; Infections Disease/Infection Control; Person-Centered/Person-Specific Needs;

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			Trauma-Informed Care and Practice; and Cultural Competency. In the absence of the peer parent network the wraparound facilitator they may link the parent with educational resources. **Status. No change**
22	3/30/21	**Entities and/or individuals that have responsibility for the service plan development may provide other direct wavier services to the participant (Page 100)** **Comment:** Change the implementation approach to one agency with provider relationships in place to provide services they do not have.	Duplicate. See number 8. Status: No change.
23	3/30/21	**Wraparound Facilitation agency cannot provide any additional CSEDW services unless a waiver is granted by BMS (Page 103)** **Comment:** This need changed	Duplicate. See number 8.
24	3/30/21	**The CANS instrument will be administered by the Wraparound Facilitator at any identified "significant life event" (Page 104)** **Comment:** The CANS cannot be completed at any "significant life event." That could be often with some families. More often than once per month would be invalid.	Thank you for your comment. This requirement has been changed to reflect that the CANS may not be administered more than once a month. Status. Change

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25	3/30/21	**Plan of care must be updated every 30 days (Page 105)** **Comment:** The current plans used indicate 3, 6, and 9-month updates. What is the purpose of the change?	The purpose of the change is to reevaluate monthly if the member and/or their family needs to add to their Plan of Care or to remove something on their Plan of Care. Status: No change.
26	3/30/21	**Should a crisis occur, or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan (Page 106)** **Comment:** Crisis plans will be updated as needed at each Plan of Care.	Thank you for your comment. The language has been changed to reflect: **Should a crisis occur, or support worker not arrive for a scheduled appointment, the individual contact information included in the crisis plan should be reviewed.** Status. Change
27	3/30/21	**For providers granted an exception to the conflict-free requirements, the State has ensured conflict of interest protections, certifying that wraparound facilitators employed by that agency remain neutral during the development of the Plan of Care (Page 112)** **Comment:** What is the process for an agency to be granted an exception to the conflict-free requirement? Where/who is the request sent?	The purpose is to ensure we are following the federal mandate for conflict-free case management and we have documentation if we are unable to do so due to lack of providers in the area. The CSEDW Program Manager receives any request from the MCO. The CSEDW Program Manager will either approve or not approve the proposal based on information gathered during inquiry as to why a waiver should be approved. Status: No change.
28	3/30/21	**Any Wraparound Facilitator working for a Wraparound Facilitation Agency that will be providing personal attendant services (Page 112)** **Comment:** What is personal attendant services?	This wording has been changed to: Any Wraparound Facilitator working for a Wraparound Facilitation agency that will also be providing direct care services will need to sign a Wraparound Facilitator Conflict of Interest Assurance form.

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29	3/30/21	**Number of service plan issues/problems that are responded to and remediated promptly (Page 117) The timeframes are set forth in the Member Handbook.** **Comment:** Providers need to know the timeframes.	ThChild & Family Team must meet every 30-45 days or more frequently if there is a significant life event. Status: No change.
30	3/30/21	**The use of restraints is permitted during the course of delivery of waiver services (Page 131)** **Comment:** The state should have a policy of restraint free.	Behavioral Health regulations allow restraint under certain conditions. Restraining a child should only be during severe crisis events. Please review Chapter 503 and West Virginia State Code 64-11.for reference. Status. No change.
31	3/30/21	**The two hours of In-Home Family Therapy would be conducive for whatever treatment modality the Person-Centered Service Plan (Page 174)** **Comment:** Change to Plan of Care3	Thank you for bringing this to our attention. Status: Change.